

vantage over an annuity or retirement plan which members of the AMA might secure as individuals at this time. If Congress ever provides a tax shelter for retirement plans for the self-employed, then such group plans would be advantageous and should be seriously considered by the AMA for sponsorship. Sponsoring a plan at this time with the intention of later taking advantage of any tax shelter provided by Congress is impractical or impossible due to present lack of knowledge of the provisions of the tax shelter and difficulty of conversion of a retirement plan once started.

The Board of Trustees further concludes that it is impossible for the AMA to provide a long-term disability plan which "will not compete" with existing plans available to members of the AMA through their county, state and specialty medical associations. Although there is some conflict with the directives of the House, the Board has developed a plan of group disability insurance which it believes meets the needs of the members of the AMA. The Board therefore recommends for sponsorship by the AMA a group disability program with Lumbermens Mutual Casualty Company as carrier and the Charles O. Finley Company as insurance broker. An abstract of the plan is available for the reference committee.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS: The following report, presented by Dr. Kenneth C. Sawyer, *Chairman*, was adopted:

Your reference committee has studied Supplementary Report K of the Board of Trustees containing the historical background relating to group annuity or retirement and group disability insurance programs for the AMA and is grateful to the Board for its analysis and conclusions regarding this most complicated subject.

Much affirmative testimony was heard. Therefore your reference committee agrees with the recommendation of the Board that a national group disability insurance program be initiated for members of the American Medical Association.

The committee, however, urges all members of the House of Delegates to study the Board's report with great care and familiarize themselves with the limitations of such a program.

Because of the complicated nature of the program as a whole and because of lack of time precludes investigation of all of the facets thereof, your reference committee would recommend that the House of Delegates authorize the Board of Trustees to use its good judgment and sound discretion in the selection of a carrier.

L. Medical Disciplinary Committee

As authorized by the Board of Trustees at its May 1961 meeting, the report of the Medical Disciplinary Committee with the exception of the recommendations, was distributed in advance to the members of the House of Delegates.

At its meeting on Saturday, June 24, the Board also approved the attached Section XI of the report of the Medical Disciplinary Committee, which includes the committee's conclusions and recommendations.

The Board of Trustees wishes to express its appreciation to the members of the Medical Disciplinary Committee for their invaluable assistance in the preparation of this report. These members are Drs. Raymond M. McKeown, *Chairman*, Louis A. Buie, Paul G. Henley, H. Thomas McGuire and E. G. Shelley. The Board also expresses its appreciation for the services of Drs. Harold E. Jervey, Jr. and Stiles D. Ezell, consultants to the committee representing the Federation of State Medical Boards.

In discharging the committee with thanks, the Board recommends that the functions of the committee be assumed as a continuing activity of the Judicial Council of the American Medical Association.

Introduction

Sections I to X inclusive of the report of the Medical Disciplinary Committee were submitted to the members of the Board of Trustees and the House of Delegates of the American Medical Association in advance of the annual meeting, June 26-29, 1961.

Section XI, Conclusions and Recommendations, was submitted to the Board of Trustees and approved by it at its June 24, 1961 meeting. At that time the Board of Trustees discharged the Medical Disciplinary Committee with thanks. The Board then sent Section XI of the report to the House of Delegates for its consideration.

The House of Delegates on June 29, 1961, on the recommendation of the Reference Committee on Miscellaneous Business, approved Section XI of the report with minor amendments. This section as adopted is set forth on pages 67 - 73 of the report (see pages 79 - 81). In addition, the House of Delegates assigned the functions of the Medical Disciplinary Committee to the Judicial Council of the American Medical Association as one of its continuing activities.

SECTION I

ORIGIN OF THE MEDICAL DISCIPLINARY COMMITTEE

In an effort to provide effective factual information and to assess accurately the status of medical discipline, the Board of Trustees of the American Medical Association authorized the appointment of a committee known as the Medical Disciplinary Committee in November 1958. The committee consisted of Drs. James H. Berge, Paul G. Henley, H. Thomas McGuire, E. G. Shelley, and Raymond McKeown, *Chairman*. After the first meeting of the committee and on its recommendation, the Board appointed Drs. Harold E. Jervey, Jr. and Stiles D. Ezell, President and Secretary respectively of the Federation of State Medical Boards of the United States, as consultants to the committee. Dr. Louis A. Buie was named to the committee to succeed Dr. Berge upon his election to the Judicial Council of the Association in June 1960.

The committee was authorized to investigate, with the assistance of the staff of the Legal and Socio-Economic Division, the adequacy of disciplinary rules, laws, and procedures as applied to medical practice, licensure, and medical society membership, and the degree to which efficient discipline is maintained among medical practitioners.

Questions have been repeatedly raised about the need for the profession to police itself and about the activity of the profession in keeping its own house in order. By and large these questions have been raised within the profession.

What, it is asked, is the current primary obligation of state boards of medical examiners? Should they be primarily concerned with the admission of ethical and competent men into practice, or should they be primarily concerned with insuring that only ethical and competent men are permitted to continue to practice?

Who should be responsible for insuring professional and ethical conduct—the medical societies, the boards of medical examiners, or hospital staffs?

What are "disciplinary" problems?

What relation is there, if any, between grievance and disciplinary matters?

Is abuse of voluntary prepayment plans or commercial insurance a matter of discipline?

Whose responsibility is it to act when conduct inimical to the best interest of the public and the profession is permitted to continue?

Who should be primarily concerned with competence?

Who is to act, and what is to be done, when a physician exceeds his competence; when a physician continually engages in conduct which is not in good taste but which is neither unethical nor illegal; when a physician overprescribes, overcharges, or performs "unnecessary" surgery?

Who is to act, and what is to be done, when a physician continually raises his fees, just a little or quite a bit, when his patient is insured?

Who should act when illegal abortions are performed by a licensed physician, or by anyone for that matter?

What attention should be given and by whom to telephone calls or letters complaining about medical care or the charges for it or the availability of it?

Should an alcoholic's license be revoked or suspended? Should a narcotic addict's license be revoked or suspended? Should efforts be made to punish or to rehabilitate these individuals? Is an income tax violation a matter for disciplinary action?

Where is the dividing line between medical society discipline and board of medical examiner discipline?

What records or discipline should be maintained?

What publicity should be given regarding disciplinary action? What reports should be made of disciplinary action and to whom? Should the American Medical Association be regularly informed of all these actions?

How many physicians have been expelled from medical societies; how many medical licenses have been revoked recently?

To achieve its objectives and to find answers to the many questions before it, the committee agreed on the following activities:

1. To examine the standards, procedures and rules of medical societies and boards of medical examiners which deal with professional discipline and to evaluate the adequacy of the existing systems of medical discipline within the perspective of practical, ethical, and legal considerations.
2. To summarize and evaluate existing state laws and medical licensure board regulations governing medical discipline, the effectiveness of such laws and regulations, and the extent to which state licensure boards are equipped to or do maintain satisfactory medical discipline through revocation or suspension of medical licenses.

3. To study the extent to which discipline is maintained by medical staffs in hospitals throughout the United States.
4. To determine whether the AMA could or should become more active in guiding and participating in matters relating to medical discipline; and if an affirmative finding is made, to recommend the establishment of appropriate mechanisms and procedures to carry out such participation efficiently.
5. To conduct fact-finding surveys and field investigations, through regional or sectional studies, as a basis for reporting on the problems relating to medical discipline and recommending appropriate measures to improve the over-all mechanism of equitable medical discipline in the interests of the public and the profession; and
6. To recommend and draft, if necessary, based on the results of thorough studies and investigations, new legislation or amendments to existing legislation, or to recommend, if necessary, additional procedures for medical societies in order that the quality of patient care may be improved by maintaining adequate standards of medical discipline.

A full statement of the purposes and objectives of the committee is set forth in *Appendix 1*.

Four regional meetings were held by the committee. Representatives of 27 state medical associations and 24 state boards of medical examiners attended these conferences.

Letter questionnaires were mailed to each state board of medical examiners, each state medical society, and several of the larger county medical societies. Replies were received from 37 state boards and 38 state medical societies.

Staff of the Legal and Socio-Economic Division personally interviewed officials of 15 medical societies and 15 state boards of medical examiners.

A chart, *Appendix 2*, shows the participation of each state in this study.

In addition, the committee met with representatives of the National Association of Blue Shield Plans, the Health Insurance Council, the Association of Casualty and Surety Underwriters, and the Association of American Railroads.

The committee has been aware that the matter of medical discipline has long been of concern to the American Medical Association.

In December 1953 the Committee on Medical Practices was appointed by the AMA House of Delegates to study all aspects of the problem of public relations created "by recent adverse publicity" and to study professional relationships particularly as they affect the quality and the cost of medical care.

The Committee on Medical Practices made a study of the disciplinary system of medicine, surveying various county societies to determine to what extent they were assuming responsibility for the maintenance of ethical standards of their members. The committee found some of the counties fulfilling their obligations, while others showed a decided lack of activity.

The report of the Committee on Medical Practices was submitted to the Board of Trustees in November 1954, which submitted it to the House of Delegates with the following comments, among others:

The Board of Trustees has given serious consideration to the report of this special committee. The vast majority of physicians are honest and sincere, but there are those who, because of dishonesty or because of economic or financial pressure, disregard standards of ethics and flaunt the fundamental principles of right and wrong. These are the ones who reflect discredit on the entire profession.

The committee has suggested two general courses of action that can be taken in the effort to combat unethical practices; (1) to remove the factors that tempt physicians to be unethical; and (2) to discipline those who are guilty. . .

The Board is determined that the public, and the good name of the profession, shall be protected from the small minority of physicians who engage in unethical practices. Mediation committees must be encouraged to fulfill their obligations, and they might well adopt the recommendations of the committee with reference to soliciting the support of leaders outside the profession. County and state societies must be stimulated to put their own houses in order when it becomes necessary. The Joint Commission on Accreditation of Hospitals must be encouraged in its efforts to effect and maintain high standards of professional work in hospitals.

The Medical Disciplinary Committee hopes that its study will prove to be the most comprehensive and most factual study of medical discipline conducted by the Association and that the specific recommendation that it includes will help implement efforts to protect the public and the profession from the minority of physicians who are guilty of unethical or unlawful practices.

These studies have been conducted with full realization of the favorable fact that physicians have been permitted by society to maintain discipline within the profession. This privilege places upon medicine the obligation to establish and support workable disciplinary mechanisms, to employ them without hesitation, and to re-

port results periodically. The committee is also mindful of the fact that unless the profession's obligation to maintain high standards of ethical and professional competence is fully discharged, others will be called upon to assume this responsibility.

SECTION II

ANALYSIS OF LETTER QUESTIONNAIRES

State Medical Societies

Immediately after the first meeting of the Medical Disciplinary Committee a letter questionnaire was prepared, approved by the committee, and mailed to all state medical societies and to a selected number of larger county medical societies. The letter, which asked five specific questions, was designed to obtain an over-all appraisal of medical discipline from the perspective of medical societies.

The following is a restatement of the questions asked and a summary of the replies received.

QUESTION 1 - IS THERE A NEED FOR MORE EFFECTIVE DISCIPLINARY PROCEDURES?

Seventeen state medical societies replied that there is no need for more effective procedures. Ten said that there is. Ten replies were not specific, and 14 state societies failed to reply. In four instances where state medical associations expressed the belief that there was no need for more effective procedures, county medical societies within the states expressed a contrary point of view. In two states, both the state and county associations expressed the opinion that there is a need for more effective procedures. In one state a county society thought there was no need for more effective procedures, while the state association expressed a contrary view. In three instances the state associations did not reply, but county societies within the states which did reply expressed conflicting views.

Significant among the replies are comments such as these:

The procedure really does not determine the extent to which the county society undertakes disciplinary functions; rather medical leadership's appreciation of the need is the determinant . . .

Inasmuch as professional discipline is a most difficult thing at best, we certainly would like to have more effective methods of carrying out this type of control.

We feel disciplinary procedure is fairly adequate provided care is exercised in choosing the personnel and the committee charged with this responsibility.

I believe we have the machinery for such discipline, but physicians themselves are reluctant to press charges. We have no particular disciplinary problems with our members.

We believe we have adequate procedures of professional discipline. However, I do believe that a regional or district grievance committee would be more appropriate. . .

These procedures sometimes fail to achieve their intended purpose because of a natural reluctance on the part of the committee to take immediate and strong enough action.

There is a tendency on the part of volunteer committees to dodge the real issue in some instances, possibly because a full scale investigation might involve considerable time and some personal embarrassment.

There is no need for more effective procedures, but there apparently is a need for more effective utilization of existing procedures!

Until physicians practicing in a community will state a man is incompetent, I believe everybody is wasting his time concerning himself with the problem. Somebody has to "bell the cat."

QUESTION 2 - WHAT ARE THE MAJOR DISCIPLINARY PROBLEMS IN YOUR STATE?

In four states and three counties, it was reported that there are no major disciplinary problems.

The following problems, listed in order of frequency, were reported by state medical societies: (1) overcharging (excessive fees, high fees, failure to explain in advance to patient, double set of fees); (2) abuse of health insurance plans (overcharging, charging for services not performed); (3) narcotic addiction; (4) advertising; (5) unnecessary surgery; (6) fee splitting; (7) professional incompetence; and (8) association with cultists.

The following problems, listed in order of frequency, were reported by county medical societies: (1) overcharging; (2) advertising; (3) professional incompetence; (4) refusal to respond to requests for service; (5) perversion of medical testimony; (6) fee splitting; and (7) abuse of health insurance plans.

QUESTION 3 - HAS THE MATTER OF DISCIPLINE IMPROVED OR DETERIORATED RECENTLY?

Thirteen state medical societies and 22 county societies reported that there has been an improvement recently in the matter of discipline. Two states reported deterioration, and three reported no change. There was no answer or no usable answer to this question from the remaining states. No county society reported deterioration.

The following are some of the more significant observations.

There has been improvement, probably because of better organization of medical associations and because of outside pressures upon medicine to police its own ranks.

There has been improvement because of a division of the society jurisdiction into districts, bringing disciplinary procedures down to the so called "grass roots."

Improvement, but still encounter legal fears or blocks when disciplinary problems are faced.

There is a definite trend towards facing the fact that the physician must accept the responsibility of self-discipline to improve public conscience and to better public relations. I do not wish to imply that public relations is the sole underlying motive because I believe the trend is based on a more serious desire to improve the quality of medical care and to protect the public.

There has been some improvement on the part of professional groups due to the greater realization of the responsibility of the profession to police its own ranks.

There has been a marked improvement in recent years due to the efforts of officers and communities. This is still, however, a tendency to whitewash at local level in some areas.

I do not think there has been any improvement in the role of professional discipline, and I think there may have been some deterioration because doctors, partly as a result of legal advice, are less willing to publicly criticize or punish members of the profession.

There is a growing awareness among physicians that ethical practice, as well as guarantees of competence and quality care, are implicit in preserving the free enterprise system.

There has been improvement, but there is considerable room for greater improvement. People are finding out that they have a place to go when they have a grievance against a physician.

We have had a decided improvement. We have publicized our professional relations committee and its duties in the local press. All new members of our society are made aware of the work of the Professional Relations Committee at orientation meetings.

The grievance committee is becoming increasingly aware of its responsibilities to the public and the profession. It is now willing to undertake the type of investigations it sometimes avoided in the past, and is not at all reluctant to request physicians to appear for a personal interview.

Generally speaking, there has been an improvement. . . We are now aware that quick, decisive, impartial, and effective action by the appropriate bodies is essential to maintaining proper discipline.

QUESTION 4 - WHAT PROBLEMS IN THE FIELD OF DISCIPLINE SHOULD BE THE CONCERN OF A DISCIPLINARY COMMITTEE?

The following complaints were most frequently brought to the attention of the disciplinary committee of a state medical society: (1) overcharging; (2) unethical conduct (advertising; unjustifiably holding oneself out as being competent; deviations from the spirit of the Hippocratic Oath; activities detrimental to best interest of the public or profession); (3) substandard care; (4) abuse of prepayment and insurance mechanisms. Three state societies suggested there should be no limitation to the jurisdiction of disciplinary committees. Three states expressed the belief that it is the obligation of such committees to educate the membership about proper conduct.

County medical societies expressed the opinion that disciplinary committees should concern themselves with (1) the conduct of physicians detrimental to the public; (2) unethical conduct generally; (3) abuse of health insurance program or companies; and (4) perversion of medical testimony in court. One county society believes there should be no limitation on matters which should be of concern to such a committee. One county society believes "organized medicine should not leave the determination of competency to hospital medical staffs or to state boards of medical examiners."

QUESTION 5 - HOW MANY MEMBERS OF YOUR SOCIETY HAVE BEEN CENSURED, REPRIMANDED OR EXPELLED IN THE LAST TWENTY-FOUR MONTHS?

It should be noted that the letter asking for this information was dated July 7, 1959. Replies are summarized as to "offenses" for which disciplinary action was taken.

Major offenses for which disciplinary action was taken between July 1, 1957, and July 1, 1959, include (1) overcharging insurance companies (five states reported action of this nature); (2) narcotic law violations; (3) advertising; (4) gross overcharge for services; (5) professional incompetence; (6) refusal to cooperate with committees of the society; (7) refusal to respond to requests of grievance committee; (8) improper testimony in personal injury cases; (9) irregularity in use of then-scarce Salk vaccine; (10) associations with cultists; (11) abuse of patient; (12) income tax evasion; (13) performing abortions; (14) forgery; and (15) perjury.

Replies to a letter mailed in January 1961, to both medical societies and state boards are summarized in *Appendix 3-A* and *Appendix 3-B* as to the number of disciplinary actions taken for the calendar year 1960.

State Licensure Boards

The secretary of each state board of medical examiners was asked, by letter, to comment on medical discipline from the board's point of view. Replies of varying degrees of usefulness were received from 34 states.

Some state boards are obviously more advanced than others. California, New York, Ohio and Oregon, to name a few, have particular mechanisms that seem helpful. California reports fully and completely each year to the governor. There is no doubt about or concealment of its activities. New York has helped develop statutory provisions and board regulations to a high degree. Ohio has an apparently effective investigation system; *all* complaints are referred to investigators, who ascertain the facts of the case. For example, in 1958, 2,666 calls were made in Ohio, including investigation of licensed as well as unlicensed practitioners. Approximately 50 cases were heard by the board in this period. Oregon has a highly refined record system and a well developed method of checking into an applicant's moral and medical background before issuing a license.

Perhaps the most significant observation to be made from the replies from the state boards is that the respondents generally proved to be unable or unwilling to discuss problems of medical discipline in useful ways. There was a sizable number of replies which expressed the view that discipline is either something of secondary importance or something not to be discussed.

Comments

The lack of responses from state boards and state medical societies and the lack of details in many of the responses received limited the usefulness of this portion of the committee's survey. Few, if any, of the boards commented in detail about (1) administration of the board; (2) its relation to state government; (3) its relation to the state medical association; (4) the nature of complaints referred to the board; (5) the disposition of complaints; (6) the method of hearing complaints; (7) the nature and extent of punishment imposed; (8) the use of probation or stay of execution of punishment; (9) legal problems experienced; (10) unusual cases; and (11) innovations tried or adopted to improve the administration of discipline.

SECTION III

PERSONAL INTERVIEWS

Staff of the Legal and Socio-Economic Division interviewed representatives of 15 state medical societies and 15 boards of medical examiners.

A series of questions was presented to state medical society representatives, and another series of questions was given to representatives of state boards of medical examiners.

The following is a general recapitulation of the answers received:

State Societies

QUESTION 1 - WHAT BODY OF THE SOCIETY IS CHARGED WITH HANDLING DISCIPLINARY PROBLEMS?

(1) The council of the state society; (2) its judicial council or committee; (3) mediation committee; (4) grievance committee; (5) state professional relations committee; (6) board of councillors; (7) board of directors acting as a grievance committee; (8) patient-physician relation committee.

QUESTION 2 - IS THERE ANY PRESCRIBED MANNER OF MAKING COMPLAINTS?

By far, most societies interviewed stated complaints could be made by anyone, but such complaints had to be in writing. It is a general practice to request individuals who telephone or pay a personal visit to the medical society office to submit their complaints in writing. One county society will consider only written complaints which are accompanied by a consent signed by a patient authorizing the (grievance) committee to review all records pertaining to the case.

QUESTION 3 - IS THERE A PRESCRIBED METHOD FOR PROCESSING COMPLAINTS?

The answers were evenly divided. Where there is a prescribed method, it is usually set forth in the bylaws of the state society.

QUESTION 4 - IS THERE A PRESCRIBED OR USUAL METHOD FOR HEARING COMPLAINTS?

The majority of states interviewed do not have a prescribed method of hearing complaints. However, the method usually followed provides that the accused will be advised of the nature of the charge and given an opportunity to defend himself. Generally, the accused may be represented by legal counsel. Generally, when there is a formal full scale hearing, the doctor is afforded opportunity to face his accuser. In informal hearings, the reverse is generally true. In these cases an effort is made to resolve rather than try the case, with only the doctor and the committee being present.

QUESTION 5 - WHAT RELATION IS THERE, IF ANY, BETWEEN THE STATE BOARD OF MEDICAL EXAMINERS AND THE STATE MEDICAL SOCIETY?

In some states the medical society nominates the members to serve on the board; in some states the same individual serves as secretary of both the state society and the state board; in one state the board is elected by the society members. In some states, while there is no official or formal relation, the existing relationship is "informal, friendly and very good."

QUESTION 6 - HAS THE SOCIETY REFERRED COMPLAINTS TO THE BOARD FOR ACTION OR FURTHER ACTION?

Replies indicated that the large majority of societies do refer cases, formally or informally, to the state board. One state society replied by saying the county medical society can handle disciplinary matters itself without any recourse to the state society or the board!

QUESTION 7 - WHAT COURT ACTIONS HAVE RESULTED FROM ACTION BY THE STATE OR COUNTY MEDICAL SOCIETIES?

Of the 15 societies interviewed, only two states reported that litigation resulted from action taken by the state or county medical society. Four cases arose in California in the last 20 years. All were decided in favor of the medical society.

QUESTION 8 - ARE THERE STATUTES OR COURT DECISIONS WHICH INFLUENCE, DETER, OR ENCOURAGE ACTION BY A MEDICAL SOCIETY?

One society suggested that it was aware of the case of *United States v. Oregon State Medical Society*, 343 US 326, although the case did not deter it. Two other states suggested that fear of a common law action for restraint of trade tended to make them cautious. The remaining states replied that there are no court decisions which influence, deter, or encourage action by them.

QUESTION 9 - WHAT IS THE EXTENT OF COMPLAINTS MADE TO THE SOCIETY ABOUT NON-MEMBERS?

Two states said "many"; one said "none"; four said "a few"; two said "very rare"; three suggested that almost all practicing physicians were members of the medical society. The remaining states did not answer the question.

QUESTION 10 - WHAT COMPLAINTS HAVE BEEN RECEIVED AND PROCESSED IN THE LAST 24 MONTHS?

Only five states had accurate and available answers to this question. The explanation was that most action was taken at county level with no report being made to the state society.

QUESTION 11 - WHAT ARE COMPLAINTS IN ORDER OF THEIR GREATEST NUMBER?

Complaints about the size of fees are by far the most frequent received by medical societies. Next in order of frequency are complaints of medical incompetence of the quality of care received. Closely following this are problems of narcotic addiction, complaints about unnecessary surgery, then problems of alcoholism and advertising.

QUESTION 12 - IS ANY REPORT MADE OF THE ACTION TAKEN BY BODY OF THE MEDICAL SOCIETY WHICH HANDLES DISCIPLINARY QUESTIONS?

A slight majority of the states interviewed report in one manner or another to their House of Delegates. Usually this report is general, stating the activity of the committee during the previous year. In no case is the name of the doctor involved disclosed.

QUESTION 13 - WHAT CRITICISM, IF ANY, HAS BEEN MADE OF MEDICAL DISCIPLINARY PRACTICES IN YOUR STATE? BY WHOM?

Replies varied from "none" to "all kinds, can't be specific." The essence of many replies is summed up in this statement: "That (criticism) which has been leveled has stemmed from doctors themselves and is conversation rather than serious complaint. There has been no criticism by the public." One other comment is worth repeating. "Such criticism as exists is caused by an ignorance of the medical disciplinary procedure; a program of education should be undertaken to inform the public of the workings of this system."

QUESTION 14 - DO YOU FEEL THAT THE SOCIETY DISCHARGES ITS OBLIGATION IN THE FIELD OF MEDICAL DISCIPLINE ADEQUATELY?

One said "Medicine is too lenient"; another said the discharge of this obligation varies widely from county to county. It was suggested that medical societies might do a better job if they had knowledge of how far they could go legally and how far they should go. One society believes that patients in general feel medical societies do not act often enough and when they do, they intend to "whitewash." Seven societies felt that they do discharge this obligation adequately.

QUESTION 15 - WOULD YOU SUGGEST CHANGE IN DISCIPLINARY PROCEDURE IN YOUR STATE?

Eleven of those interviewed stated flatly no change is necessary in procedure. Three states qualified their negative answer by suggesting that there may be a different method of approach in attacking disciplinary problems. They felt that members of disciplinary committees should be carefully selected and that they should be firm, objective, courageous individuals.

QUESTION 16 - WHAT IS THE MEDICAL SOCIETY'S OBLIGATION IN THE MATTER OF MEDICAL DISCIPLINE?

The following are some of the answers received to this question: (1) To protect the public' health; (2) to correct any condition which causes a deterioration in the quality of medical care or reflects adversely on the medical profession; (3) to curtail the activities of physicians who show themselves to be a menace to the public; (4) to insure that a medical society should not govern itself under "country club" rules of membership; (5) to insure the best possible medical service to the public and to discipline its own members; (6) to discipline so that the code of medical ethics will be a consideration in the physician's daily practices; (7) to select competent men to hear and adjudicate grievances and complaints of unethical conduct.

State Licensure Boards

Representatives of 15 state boards of medical examiners were also interviewed by members of the Legal and Socio-Economic Division of the Association.

The questions which were used to elicit information are repeated below. A summary of the answers obtained during the interviews follows each question.

QUESTION 1 - WHAT IS THE SIZE AND COMPOSITION OF THE BOARD?

A wide variation was found in the size of the boards; 5, 7, 9, 10, and 15 members. In one state there are six doctors of medicine and one doctor of osteopathy on the board; in another, 12 doctors of medicine and three doctors of osteopathy; and in a third, seven doctors of medicine, two chiropractors, and two chiroprodists.

QUESTION 2 - WHAT IS THE STATUTORY AUTHORITY FOR DISCIPLINARY ACTION? (WHAT ACTION MAY BE TAKEN; WHAT ARE THE GROUNDS FOR DISCIPLINARY ACTION?)

All state licensure statutes set forth the authority of the boards. All of these statutes also authorize revocation of licenses.

QUESTION 3 - HAS THE BOARD ADOPTED RULES OR REGULATIONS RELATING TO DISCIPLINARY PROCEDURES?

Very few states have adopted formal rules or procedures to govern their disciplinary activities. For the most part, they rely on the language of the medical practice act as it prescribes procedures for revocation or suspension of license. In a few states an "administrative procedure act" prescribes the procedure to be followed.

QUESTION 4 - ARE ANNUAL REPORTS PREPARED? ARE COPIES AVAILABLE?

Annual reports were obtained from California and Oregon. Arkansas, Maryland, Oklahoma, and Texas furnished statistical information. The remaining states are not required to make annual reports or had no statistical information readily available at the time of interview.

QUESTION 5 - WHAT COURT DECISIONS OR OPINIONS OF ATTORNEY GENERAL INFLUENCE OR CONTROL THE ACTION OF THE BOARD?

One state reported appeals had been successfully taken against four of its recent actions. One state said the scope of its authority in licensure matters was established by a 1959 Supreme Court decision. In the same state an unreported case holds that the board has authority to suspend a license but does not have authority to revoke a license without court action. One state reported it relied on a technicality to secure the suspension of the license of an abortionist. (Suspension followed failure to report a case of a venereal disease.)

QUESTION 6 - WHO MAY COMPLAIN OF CONDUCT CONTRARY TO LAW?

While the almost universal answer was "anyone," it may be noted that in one state the majority of complaints are made by the board's investigator, and in another by the board itself on its own motion. One state permits anyone to make a complaint, but it must be in writing and under oath.

QUESTION 7 - HOW ARE HEARINGS CONDUCTED?

In one state hearings are public as in the trial of a case in a court of law; in several other states hearings are held according to the provisions of specific statutes. One state reports it conducts informal hearings because there has been no request to do otherwise; in one state, attorneys for both sides are usually present. In one state a formal public hearing is held with the attorney general or his designee and the attorney for the accused present.

Stenographic transcripts of testimony are kept by a majority of the boards. One board advised that it has power to subpoena books, records, etc. and to compel the attendance of witnesses. In this state the board's findings must be based on "sufficient legal evidence."

QUESTION 8 - WHAT RELATION IS THERE, IF ANY, BETWEEN THE BOARD AND THE STATE MEDICAL ASSOCIATION? WHAT IS THE PRESENT RELATIONSHIP BETWEEN YOUR BOARD AND THE AMA WITH RESPECT TO THE EXCHANGE OF INFORMATION RELATIVE TO DISCIPLINARY MATTERS?

The relationships are "informal but cooperative" and satisfactory from the board's point of view. Several state boards were particularly complimentary of the service provided by the American Medical Association's Department of Investigation.

QUESTION 9 - HAS THE STATE MEDICAL ASSOCIATION EVER REQUESTED OR RECOMMENDED THAT THE BOARD TAKE DISCIPLINARY ACTION?

Answers indicate that, although there have only been a few such requests in the past, there is a trend in this direction. The request generally is informal and stems from the rapport which exists between the two groups. (Refer to question 6, page 17 [of report, see page 61 of proceedings] for state medical association point of view.)

QUESTION 10 - HOW DOES THE BOARD KEEP ABREAST OF MEDICAL SOCIETY ACTIVITIES RELATIVE TO DISCIPLINE OF MEMBERS?

In some instances through the sharing of office space, in others because the two have a common secretary, in still others because members of the board are active in society affairs. Only two boards said that they receive reports of disciplinary action from the state medical society. All other state boards report that the relation is a tenuous and informal one.

QUESTION 11 - DO THE STATES HAVE AN ADEQUATE BUDGET TO CARRY ON THE INVESTIGATION OF PHYSICIANS SUSPECTED OF BEING UNWORTHY OF LICENSURE?

Five states said yes; another said "only because the board and the state society share office space and staff"; another said, "There is no budget for such purpose and none is presently thought to be needed." One state said no, and since it has no money it is reluctant to tackle any difficult case because there is no money for investigators, court reporters, and attorneys. Five states said their budget is inadequate. One state said the budget is not adequate to cover the expenses of what should be done, but it does permit a limited operation of the office.

QUESTION 12 - WHAT IS THE EXTENT OF DISCIPLINARY ACTION AGAINST PHYSICIANS WHO ARE NOT MEMBERS OF MEDICAL SOCIETIES?

Of the states having information on this question, six indicated that there is no difference in extent of disciplinary action taken against non-members; two said there is no difference in ratio of actions taken; and two said that, because almost all practicing physicians in the state are members of the state society, little or no problem is encountered with non-members.

QUESTION 13 - WHAT COMPLAINTS HAVE BEEN RECEIVED AND PROCESSED WITHIN THE LAST 24 MONTHS?

About 1,000 were received and processed in California; in another state there were 39 appearances before the board resulting in action being taken against ten physicians. In another there were 630 complaints processed, resulting in 47 hearings, in which actions were taken in 32 cases including six revocations. Two states report no record is maintained. The remaining states report figures under 15.

QUESTION 14 - HAVE LICENSES BEEN REVOKED OR SUSPENDED FOR INCOMPETENCE, ALCOHOLISM, NARCOTIC ADDICTION, CONVICTION OF A CRIME?

Licenses have been revoked for the following reasons, listed in order of frequency mentioned: narcotic addiction, income tax evasion, performing abortion, alcoholism, mental illness, and conviction of a crime.

QUESTION 15 - WHAT HAPPENS WHEN A LICENSE IS REVOKED OR SUSPENDED IN YOUR STATE AND THE PHYSICIAN MOVES TO ANOTHER STATE TO PRACTICE UNDER EITHER A PREVIOUSLY ATTAINED OR A NEW LICENSE?

One board notifies "reciprocating states"; another admits "little or nothing" is done. Others notify the Federation of State Medical Boards, states in which the physician holds another license, the AMA or a combination of the three.

QUESTION 16 - WHAT ARE THE CAUSES USUALLY INVOLVED IN MEDICAL DISCIPLINARY CASES?

In the order of frequency mentioned the causes are narcotic addiction, alcoholism, mental incompetence, income tax evasion, abortion, falsifying (padding) insurance claims, aiding unlicensed person to practice, and conviction of a crime involving moral turpitude.

QUESTION 17 - WHAT CRITICISM, IF ANY, HAS BEEN MADE OF DISCIPLINARY PROCEDURES IN YOUR STATE?

All except five boards replied that there is none. One state said that a doctor-member of the state legislature is critical of the board and seeks to reduce its discretionary power. One other state said that the supreme court was critical of the board in a decision setting aside a license revocation.

QUESTION 18 - DO YOU FEEL THE BOARD FUNCTIONS ADEQUATELY IN THE DISCIPLINARY FIELD?

Two states said the board is handicapped by inadequate budgets which prevent investigation of difficult cases. The remaining states answered that the board functions adequately in disciplinary matters.

QUESTION 19 - WOULD YOU SUGGEST ANY CHANGE IN DISCIPLINARY PROCEDURES?

One state suggested a change which would permit one member of the board to be a "hearing examiner." Under such a system a record could be made for review by the entire board. The advantage of such a system would include savings in time and expense. Another state suggested it would like permission and a budget to employ a competent investigator. Eight states specifically state no change necessary.

QUESTION 20 - IS THERE A NEED FOR AMENDING THE PRESENT MEDICAL LICENSURE LAW IN ORDER TO TIGHTEN DISCIPLINE?

One state would like to see the law amended so that when an appeal is taken to court from an action of the board, the burden would be on the physician to show that a board was incorrect in its action or that it acted on insufficient evidence. (In that state, in an appeal to the court, the burden is on the board to prove its case.) One state believes the law should be amended to permit the use of hearing officers by the board. Another state believes that the law should be changed to permit the board to take disciplinary action in cases of gross malpractice. Another state thinks the law should be changed so that the board can grant probation. Still another state, admitting its law is "meager," fears to ask for any strengthening amendments because of unpredictability of the legislature. The remaining states all expressed the belief that no change is necessary.

QUESTION 21 - IN WHAT WAYS COULD LOCAL, STATE, AND NATIONAL ORGANIZATIONS HELP THE STATE BOARDS PROVIDE MORE EFFECTIVE DISCIPLINE?

1. Local and state organizations could acquaint membership with the necessity of reporting all violations of the medical practice act.
2. Individual society members could aid and assist in investigations of alleged violations.
3. General cooperation among the states.
4. "Perhaps the American Medical Association might be instrumental in promoting a better exchange of information."
5. AMA could report what's going on elsewhere and make suggestions on an "if requested" basis.
6. Have the American Medical Association memorialize state legislatures to appropriate adequate funds to finance board investigations.

7. Encourage, if possible, the development of a strong executive office for the Federation of State Boards.
8. Improve exchange of information at all levels and between medical societies and state boards.
9. By widespread publication of revocations, etc. through medical society publications.
10. AMA might provide "background information about an applicant's character and behavior in the hospitals in which he has practiced."
11. AMA could assist by helping in some manner to establish a national clearing house of information on physicians.
12. AMA might provide investigators for the use or assistance of state boards.
13. County societies should be more diligent in maintaining discipline among members.
14. Medical societies should report any apparent violations of the medical practice act to the state board and should assist in obtaining evidence to present at board hearings.

SECTION IV

REGIONAL CONFERENCES

The committee held four regional conferences, to which representatives of all state medical associations and all state boards of medical examiners were invited. Twenty-seven state medical associations, and 24 state boards sent representatives to these conferences. All in all, the committee found a great deal of similarity in the discussions at all conferences. At two sessions the states' representatives, while sincere and conscientious, did not have disciplinary problems, were not aware of them, or were reluctant to discuss them. The impression created at another conference was that while the states had problems, the states felt more than competent to take care of these problems without outside assistance. Representatives at the other conference participated in a full, free, and uninhibited discussion.

The committee was interested in individual cases only as examples of the effectiveness or ineffectiveness of present procedures.

Some of the examples cited by participants at the regional meetings not only illustrated functions or malfunctions of disciplinary procedures but demonstrated the complexity of the problem of medical discipline. Illustrative of the nature of the problems confronting medical societies were the following: (1) The doctor who billed Blue Shield for removing his daughter's appendix in 1959. Blue Shield records showed an identical billing in 1956. Hospital records disclosed the 1959 procedure was a salpingectomy. (2) The physician who treated each of his patients with a "flu shot" regardless of the patient's age or disease. (3) The physician who was practicing under a license granted on reciprocity from another state despite the fact the other state had since revoked the original license because it had been obtained with fraudulent credentials. (4) The "industrial" clinic which is open 24 hours a day although staffed by medical students and/or unlicensed persons during night hours. (5) The physician who billed his patient for a new suit because the patient's bloody condition ruined the doctor's old suit. (6) The doctors who bill Blue Shield and commercial insurance companies for procedures other than the one performed. (One physician charged for cauterization of the nose, investigation disclosed he had been using a styptic pencil to "cauterize.") (7) The physician who testified that multiple sclerosis could result from surgery. (8) The physician in one state who performed 29 procedures indemnified at \$400 apiece by Medicare, whereas only one such procedure was performed during the year by all the other physicians on the program. (9) The physician who testified repeatedly for the same firm of attorneys, always supporting the patient's claim by his medical opinion.

In addition, there are the abortionists, the narcotic addicts, the alcoholics, the mentally incompetent, and the professionally incompetent. There are those who overcharge; there are those who charge one fee when the patient has no insurance and a much higher fee if the patient is insured. There are those who perform unnecessary surgery. There are those who consort with quacks and faddists. There are those who advertise subtly and those who advertise openly. There are the fee-splitters and the rebaters.

On the positive side are the indoctrination programs of many medical societies designed to acquaint new members with ethical principles and with socioeconomic practices. There is the use of probationary membership to appraise the character, competence, and moral fiber of the applicant. There are the documents and the lectures sponsored by state medical associations on the dangers of narcotics and on the nature of narcotic laws and the obligation imposed by them. There are the more than 1,100 grievance committees which have "come of age" and are functioning so effectively. There is the extension of the use of probation and suspended sentence by state boards. There are programs of state boards designed to rehabilitate physicians addicted to alcohol and narcotics. One state board is collaborating with the psychiatrists within the state in an effort

to establish a program to rehabilitate physicians who are mentally incapacitated. There are reports of more and more societies and boards using legal counsel to obviate or prevent legal problems. So-called "review" or "utilization" committees are being established all over the country to consider insurance abuses.

These are the impressions and the problems outlined by representatives of state boards of medical examiners.

State Licensure Boards

There was little or no discussion at the regional conferences of existing procedures and the manner in which cases are handled. None of the representatives of the state boards attending the regional conferences presented an annual report of his board's activities, a copy of its rules, or the forms which it uses (i.e., to notify an accused physician of a complaint, etc.) in its disciplinary procedures. Activities of investigators for boards, where there are investigators, were glossed over. (In one instance, it was mentioned that the board's investigator also investigated complaints received by other boards, such as the board of cosmetology, under a central licensing authority.)

State Medical Societies

Representatives of state medical societies at the regional conferences shed little light on the adequacy and use of disciplinary mechanisms.

Almost without exception the states expressed this opinion: Discipline is a local matter, and since county societies handle discipline, the states have little or no knowledge of what is being done. No state conducts disciplinary procedures *de novo* or originally. Jurisdiction by state societies in cases is obtained only through appeal procedures. Despite the emphasis on local responsibility no method of encouraging county societies to be more active and no means of advising county societies of problems or procedures were discussed by the representatives of state medical societies.

A good number of state societies pointed with seeming pride to the fact that members of the state boards of medical examiners were appointed from nominees submitted by the society. The inference was clear that the nomination was thought by the state medical society to be its major contribution to the disciplinary effort.

Some societies expressed fear that they would become involved in litigation of one sort or another if they pursued an aggressive disciplinary program. Among this group, their action (or lack of it) was rationalized on the basis that these problems take care of themselves in time or they are taken care of by the action of medical staffs and governing boards of hospitals.

SECTION V

DISCIPLINARY PROBLEMS INVOLVED IN INSURANCE AND PREPAYMENT PLANS

Representatives of the Health Insurance Council attended a special session of the committee held in conjunction with one of its regional conferences.

HIC is well aware that there are mechanisms throughout the country at the county and state medical society levels for the handling of *complaints* against physicians. HIC, however, has been urging medical societies to establish separate communities, to be called insurance review or insurance advisory committees, both for the evaluation of the reasonableness of charges by a physician and as an aid in ascertaining the usual and customary fees charged in that particular area. The operation of such committees serves a two-fold purpose. First, it resolves some difficult situations while preserving in the minds of all parties concerned a favorable atmosphere for the private practice of medicine and for voluntary means of financial medical care. Second, the very operation of such committees provides a means of education for both the physicians and the insurance companies.

Several medical societies have established review committees to provide the type of mechanism described above. In each instance the local society has provided a method of operation to suit the needs of the local area. However, there is a close similarity in the procedure established. In general, the basic procedure in these, and other committees, is as follows:

1. Insurance companies presenting claims to a committee for review must first attempt to reconcile the specific problems involved by personal contact with the physician. It has been suggested, however, that the review committee might also provide an informational service where the insurer could get informal service without first questioning the physician's charges.

2. Failing reconciliation with the physician, the claim is presented to the review committee. Generally the claims are presented to the committee without identification as to the specific parties involved in order to assure an objective consideration by the physician members of the committee.
3. The decision of the committee may be made known only to the insurance carrier for its further handling or may be announced jointly to the physician involved and the insurance company. This procedure varies among the several committees that are in operation.
4. The decisions of the committee are advisory and educational in nature and are intended to resolve the differences between the physician and the insurance company in the settlement of a claim on the basis of reasonable, usual, and customary charges in consideration of all the medical and economic factors of the particular case. In most cases the claim is then settled satisfactorily; however, if there is failure to agree, the normal grievance procedure of the medical society is available for a further hearing of the problem.
5. The type of review by the medical society committee may vary from place to place. In some instances the committee may consider questions pertaining to the reasonableness of a physician's fee and whether the utilization of diagnostic and therapeutic services was appropriate to a particular case. In other situations the review committees may confine their activities strictly to fee problems and rely upon utilization committees operated by the medical staffs of the local hospitals to determine the appropriate utilization of hospital services.

Regardless of procedural details, HIC sees in the review committee concept a necessary additional means of assuring the continued success of voluntary health insurance.

A representative of the National Association of Blue Shield Plans also attended a special session of the committee. In an effort to assist the committee he offered to and did conduct a survey of affiliated Blue Shield plans. Forty of 68 plans responded to a questionnaire mailed them. It was his conclusion from the survey that misuse of Blue Shield plans is a problem but that the plans are anxious to contribute to its solution. Based on the survey he advised the committee:

Until proper criteria and definitions are developed, research will continue to be limited to disjointed, individual efforts. Guidance from the national level appears to be in order, to weld the resources of all interested organizations into an effective program directed at the solution of the problems of misuse.

Additionally, representatives of the Association of Casualty and Surety Underwriters appeared before the committee. They were critical of the conduct of doctors who testify for plaintiff attorneys in personal injury litigation, doctors who exaggerate the nature and extent of a patient's illness or injury in order to warrant a higher recovery from an insurance claim, and the like.

These representatives stated that they had investigated the conduct of "several hundred" doctors in New York and were convinced that many of them were guilty of fraud. They cited several cases as examples. The representatives stated they did not and probably would not make their records and investigation reports available to medical societies or boards of medical examiners but that they have complained to both groups about men whose conduct they question.

Review Committees

A number of "review" committees have been established. In general, the purpose of such a committee is to analyze and identify factors that may contribute to unnecessary and ineffective use of medical and hospital services (and insurance coverage) and make recommendations designed to minimize ineffective utilization.

The Tenth Councillor District of Pennsylvania Medical Society pioneered in the development of this type program, as did the Nassau County Medical Society in New York. Since their early efforts, other have established similar programs.

The Committee on Insurance and Prepayment Plans of the AMA's Council on Medical Services is alert to the development of review committees and is making a critical study of them and their effectiveness.

SECTION VI

BYLAW PROVISIONS OF MEDICAL SOCIETIES
REGARDING DISCIPLINARY PROCEDURES

The bylaws of medical societies concerning discipline and disciplinary procedures differ widely. Some are brief and ambiguous, some are brief but effective, some are detailed, and a few are very detailed.

Initially it is noted that in identifying the conduct for which disciplinary action may be taken most bylaws are extremely general in nature. Secondly, state bylaws generally provide a mechanism for appeal from action initiated at local level. They do not, however, ordinarily provide mechanisms for hearing disciplinary questions originally.

The names of disciplinary bodies vary, i.e. councillors, boards of censors, executive committees, grievance committees, judicial or judiciary committees. The size of the committees varies, as do the means of selecting the members. Specified offenses include violations of the *Principles of Medical Ethics*; malfeasance by an officer; neglect of constitutional duty; immoral, ungentlemanly, or unprofessional conduct.

Procedural provisions possess no semblance of uniformity. Among the items which usually do appear, however, are provisions regarding (1) the method of filing a complaint (in general it must be in writing); (2) the person who may bring a complaint; (3) notice to the accused; (4) time and place of hearing; (5) right to defend (6) right to counsel; (7) right to confront accuser; and (8) right of appeal. Some bylaws provide for an investigation of a complaint before a formal charge is filed. The financing of the disciplinary committee and its staff is not provided for in the bylaws. Only a few bylaws spell out the type of record to be kept of investigations and hearings. Some few bylaws provide for withdrawal of a disciplinary committee member because of personal or professional relationships with the parties.

Penalties are usually stated to be censure, suspension, or expulsion. One bylaw defines what is meant by "censure." Some few bylaws provide for automatic expulsion on notification that a member's license has been revoked. Provisions regarding suspension or expulsion on the *bringing* of a criminal action (e.g., evasion of federal income tax law or violation of abortion laws) are strangely absent. Equally absent are provisions regarding suspension or expulsion after *conviction* of a crime.

Few bylaws have anything to say about stay of proceedings during the pendency of appeals.

Several bylaws provide that the state medical society may take original jurisdiction when it believes serious charges brought against an individual are not being given proper consideration by the county society concerned.

One bylaw provides that a resignation may be requested if after investigation the disciplinary committee believes a serious offense has been committed. If the resignation is not tendered, then a complaint is filed and a hearing is held.

A member of the staff of the Legal and Socio-Economic Division of the headquarters staff has prepared a number of model bylaw provisions which may be helpful to medical societies who wish to review their bylaws with the thought of making disciplinary provisions more effective. These provisions are attached as *Appendix 4*.

SECTION VII

GRIEVANCE COMMITTEES

The committee did not plan, at the outset of its studies, to consider grievances or grievance committees. It was not long, however, until the committee realized that "grievances" are integrally related to a consideration of medical discipline. They are related not by nature but because of public pressure. Patients seeking explanation, understanding, or adjustment turn to the medical society and expect an answer. The medical society is expected by the public to possess that control over its membership which will make an answer forthcoming.

The conferences, correspondence, and other activities of the committee disclosed that the major problem (certainly in volume) of medical societies in the field of complaints from the public lies in the field of grievances. Grievance committees exist in over 1100 medical societies and, as far as the Disciplinary Committee can ascertain, they are busy.

The committee was impressed by several items. First, grievance committees are becoming more active, and they are becoming more aware of the importance of their functions.

Representatives of state medical societies stressed the necessity of selecting men for the committee with care. Members of grievance committees, according to the committee's guests, should recognize their obliga-

tions to the public and medicine; they should be objective and impartial. All were in agreement that men should not be appointed to committees merely as a reward for one reason or another. Many suggested that grievance committee membership should be rotated so that as many of the members as possible would have an actual and accurate understanding of patient complaints.

One other fact was developed by the committee: medical society staff, cognizant of the importance of "mediation" and anxious to help the medical society, can handle many complaints by tactfully listening to the patient's story without comment as to its merit or lack of merit. It is for the committee only to determine whether it is meritorious or not.

The suggestion was made to the committee that consideration be given to extending the duties of the grievance committee so that all complaints, whether from patients regarding fees or the like or from members complaining of unprofessional or unethical conduct, be referred to the grievance committee. It would continue to serve as a mediation committee for true grievances and somewhat as a grand jury in all other matters. The merits of such a proposal are said to be that (1) the committee would be kept active and informed; (2) it could screen and even mediate or correct minor disciplinary problems within the membership; (3) it could frame and present a complaint to the board of censors, thus eliminating the sometimes opprobrious necessity of forcing an individual to accuse a colleague. Further, it is suggested that by use of such a procedure the board of censors, being presented with a well founded complaint, could proceed more promptly and objectively to consider it. It was also suggested that this practice of funnelling all complaints through the grievance committee would enable that committee to make suggestions and reports to the society concerning present and anticipated problems. It could help advise the society as to policy in the multi-faceted area, if disciplinary procedures had to be reconsidered or developed.

As to publicizing the grievance committee and its activities, there seemed to be agreement that this was desirable. Without publicity the public would be unaware of it. Without publicity about the activities of the grievance committee its integrity is much more slowly established, according to the committee's informants.

Only a handful of societies believe today that these committees and their activities should not be publicized.

SECTION VIII

MEDICAL PRACTICE ACTS AND DISCIPLINARY PROCEDURES

One need but read the medical practice acts of the 50 states to assure himself that the concept of states' rights is not dead. The diverse grounds specified for revocation or suspension of a license to practice medicine attest that the states in one area at least have maintained their sovereignty.

Among the states there are more than 90 reasons for the revocation or suspension of a medical license. No one ground, stated in the same words, is to be found in all medical practice acts. Nine grounds are found repeated in 30 or more state laws. These are: (1) drug addiction in 47 states; (2) unprofessional conduct (whether defined or not) in 45 states; (3) fraud in connection with examination or obtaining a license in 44 states; (4) alcoholism in 42 states; (5) advertising in 40 states; (6) abortions in 39 states; (7) conviction of felony in 38 states; (8) conviction of an offense involving moral turpitude in 36 states; and (9) mental incompetence in 32 states.

Some statutes are so drafted that unprofessional conduct, for example, applies to several acts of misconduct warranting disciplinary action. In other states a license may be revoked for a number of specified grounds including "unprofessional conduct." In some states the law provides for revocation or suspension of a license for "gross immorality"; in other states for "immoral, dishonorable, or unprofessional conduct," or "conduct unbecoming in a person licensed to practice medicine," or "unprofessional or dishonorable conduct unworthy of and affecting the practice of his profession," or "grossly unethical practice," or "grossly unprofessional or dishonorable conduct of a character which, in the opinion of the board of medical examiners, is likely to deceive or defraud the public."

A chart showing, by jurisdiction, the statutory grounds for revocation or suspension of licenses as well as the procedures for disciplinary action is attached as *Appendix 5*.

Lack of uniformity and lack of benefiting from the experience of others are reflected elsewhere in medical practice acts. For example, in one state the board of medical examiners is just one of 27 licensing agencies under a central licensing administration. Problems are minimal as far as licensing is concerned because in this state a degree of independence is conferred on the board of medical examiners in granting a license.

When this same board is called on to revoke or suspend a license, however, it is without authority. The central licensing administration is responsible. All manner of obstacles are thus placed in the way of the board or the profession seeking to take corrective disciplinary action.

The state of Washington experienced the same difficulty but through the efforts of its medical association effected a change in the law. No longer is discipline in Washington subject to the vicissitudes of political organization and change. There are several other features of the Washington law (Washington State Medical Disciplinary Board Act) worth mentioning: All physicians of the state *elect* members of the disciplinary board. Procedures to be followed by the board are delineated in the act.

The medical practice act of Iowa was recently amended also to provide a degree of independence for its board in the conduct of disciplinary procedures. This act, less drastic in its changes than the Washington law, does not provide for any election of members to the state board. Its procedural provisions, however, are worthy of note.

In 1956 the Federation of State Medical Boards adopted the *Essentials of a Modern Medical Practice Act*. This is attached as *Appendix 6*. The *Essentials* do not appear to have been followed by most states, although they have received wide dissemination among members of boards of medical examiners.

The committee was advised that the American Public Health Association at its 1961 annual meeting adopted a resolution which recommended that the Council of State Governments sponsor the establishment of a commission to study present licensing practices; to consult interested professional and academic associations, to prepare a model licensing law; and "to encourage its uniform adoption by the states so as to protect the public interest and to minimize the barriers to licensure of qualified physicians in the several states." The American Medical Association immediately notified officers of the Council of State Governments of its interest in and concern with this matter.

SECTION IX

RELATION OF THE LAW TO MEDICAL DISCIPLINE

The committee was advised repeatedly by representatives of medical societies and boards of medical examiners that a fear of litigation discouraged more aggressive action. Few of such spokesmen had tangible evidence to support this contention. A survey of court decisions by members of the staff of the Legal and Socio-Economic Division also fails to support this view. This study of court decisions reflects that:

1. Medical societies have the right to make their own rules on the subject of admission or exclusion of members and that these rules may be considered as articles of agreement to which all who are members become parties.
2. Medical societies may adopt and enforce requirements which have a reasonable connection with improving and maintaining the standards under which their members practice their profession.
3. Expulsion is authorized under established rules of the society, subscribed to or assented to by the members, which specify the violations justifying expulsion; and for conduct that violates the fundamental objects of the association which, if persisted in and allowed, would thwart those objects or bring the association into dispute.
4. The function of the court is to determine whether the society acted within its powers in good faith, in accord with its bylaws, and in accord with the law of the land.

In regard to actions of state boards of medical examiners that have suspended or revoked licenses, a review of court decisions discloses that far more appeals from board action have been sustained than overruled. It is clear that court decisions concerning actions of boards of medical examiners in disciplinary procedures establish these principles:

1. The statute which confers jurisdiction on a board to revoke licenses find justification in the police power of the state to protect public health, safety, or morals.
2. When statutes require interpretation, courts will differ. Strong evidence is demanded under ambiguous or loosely worded statutes. With strong evidence, the courts support the action of the board.
3. When a statute is clear or where the evidence is clear cut, the courts do not hesitate to support the boards.

While medical societies enjoy a reasonably broad latitude of discretion in disciplining members for unprofessional or unethical conduct in accordance with established rules, this discipline may not be properly exercised to restrain competition among practitioners.

Information acquired by the committee reflects that disciplinary action by both medical societies and boards of medical examiners is inadequate. Some county societies go for years without considering a disciplinary pro-

blem. Most state associations only consider appeals from local disciplinary action, and in many states these appeals are not numerous. Most state boards are infrequently called on to have full scale hearings on disciplinary matters. Many local societies do not have legal counsel. Some state associations do not have legal counsel on retainer or do not call on counsel for advice in disciplinary matters.

The net result is that frequently, when disciplinary action has been taken either by a medical society or a medical licensure board, it is taken without benefit of experience, precedents, or legal advice. The opportunities for error are numerous. These errors are seized upon by the physician who was disciplined as a basis for appeal to the courts.

The committee also noted from its studies that there is no interchange of experiences among medical societies or boards. Each pioneers; each goes its own way without knowledge of the experience, either good or bad, of other societies or boards. Errors are repeated rather than avoided, thus opening the door to litigation.

More important, the committee detected a negative and pessimistic attitude on the part of many spokesmen of medical societies and state boards based on this alleged fear of litigation. The mere fear of litigation seemingly deters them from acting in a number of cases. The more wholesome, positive attitude, in the committee's opinion, demands action regardless of costs and threats of litigation. The committee might here commend the Texas Board of Medical Examiners and the Texas Medical Association for their joint contribution in prosecuting a particularly difficult case to a successful conclusion before the Supreme Court of Texas. The Board of Regents of the State of New York has also developed a much good, usable law. The California Medical Association has set an example among medical societies which may be emulated by other states.

An exhaustive and highly informative review of disciplinary actions and procedures within the legal profession was prepared for the committee by the staff of the Association's Law Department. This study reflects that many problems are the same in both professions. Among these are: (1) the nature and extent of punishment; (2) the offenses which should be punished; (3) effective and efficient disciplinary procedures; and (4) the philosophy of publicizing activities of disciplinary committees.

As one contemplates the similarities of problems, one must not, however, forget dissimilarities. Organizationally the medical profession differs from the legal profession. In addition, traditionally and by statute, lawyers are officers of the court. Medicine has no counterpart of this relationship.

SECTION X

BACKGROUND AND OBSERVATIONS

The American Medical Association and the state and county medical societies have, since their inception, been concerned with the promulgation and enforcement of rules and ethics applicable to the practice of medicine. This concern has not, however, always been translated into intelligent and effective control and direction of the ethics of the profession. Knowledge of this fact dictates the necessity for a periodic survey or study to ascertain whether or not adequate mechanisms exist and, if so, whether or not they have been effective.

Medical discipline is not new. The Code of Hammurabi, compiled around 2000 B. C., nearly four thousand years ago, clearly and vividly shows the difficulties with which the practitioner of medicine was faced in that age. The document codified punishments for many of the profession's deficiencies and delinquencies. A surgeon worked at his own risk. He might have lost life or limb, depending upon his degree of success or failure. If he operated on a wound and the patient died, his hand was to be cut off. If he operated on the eye of a man and the man lost his eye, the eye of the doctor was removed. This was punishment in its most severe form.

For the past four thousand years the attitude of the public toward the physician was fluctuated between God-like veneration and man-like condemnation. However, it seems the public has generally expected more from physicians than from other individuals.

Today it would appear that the public is looking with an increasingly critical eye at failings and delinquencies of the physician. Irrespective of the cause for this situation, the demands of the public must be viewed realistically and met honestly.

In conducting a critical self-analysis, many basic questions must be answered. Of greatest importance is the need for a determination as to whether or not a disciplinary problem exists. If so, how large is it? How effectively is it controlled? Do adequate mechanisms exist within the framework of the laws and the constitutions and bylaws of medical societies to deal with the problems? How well are these provisions administered? Does the punishment fit the crime? Which offenses are, or should be, handled by state medical boards and which by the medical societies? Are the jurisdictions of these respective groups clear cut? Is there a

need for clarification? Is the liaison between the medical profession, the state medical boards, medical societies, medical schools and specialty groups in the area of discipline effective, or is there a need for additional lines of communication? Many other questions could be posed.

Today there are approximately 250,000 physicians in this country. How many of these have been, are, or will be disciplinary problems cannot be accurately established. There are no sources from which such figures are obtainable. This is a fundamental weakness in this field and needs to be corrected. Whatever the statistics are in this regard, one need only to scan the lay press to note the increasing interest and concern that the public, writers, and legislators are taking in this field. Much of what is written is biased, distorted, and exaggerated. A portion, nonetheless, is based on facts.

Teaching Ethics in Medical School

The first intimate contact that a physician has with medical ethics is in medical school. It would seem fitting then to determine the attitudes of the medical educators, the efforts that are being made to properly indoctrinate the students, how this is being accomplished, and what recommendations for improvements they might have. A questionnaire designed to determine these facts was sent to deans of all medical colleges by a consultant to the committee. Seventy-two completed forms were returned. The following brief summation represents the attitudes of the majority of educators.

Thirty schools currently make no attempt to cover the field of medical ethics and discipline with any type of formal lectures. Of the 42 schools which conducted some type of program, the majority utilized the services of various instructors, department heads, and deans. Fourteen of these schools had lectures presented by a member of the board of medical examiners.

To the question--Do students need more information in this area--18 stated no; 23, yes; two an equivocal no and 11 an equivocal yes. The remainder did not respond.

The prevailing opinion among the deans was that this material could not be adequately taught. It was better presented, they stated, by precept and by the example of the faculty and the practicing physicians with whom the student came in contact. The deans felt that better screening methods are needed to eliminate potential delinquents.

Deans of 54 medical schools indicated that neither they, nor any representatives of the school, ever attended state board meetings. Twelve deans attended regularly and six on occasion. On the other hand, 63 answered that board members never were invited to faculty meetings. Five stated they were invited under varying circumstances, and only four indicated that board members were regularly invited to attend. On the basis of these figures, it appears that such liaison as exists is grossly inadequate.

It further appears that many physicians become disciplinary problems through lack of knowledge of the laws and ethics of the profession. It should be realized that medicine is governed by laws and rules which differ in certain respects from those of the general population. The individual who has no knowledge of these rules is going to make mistakes.

If the deans had closer liaison with boards of medical examiners, they would recognize this fact. They would have a greater appreciation of the complexities in the field, the need for greater emphasis, and their proper role. They would recognize that such instruction can be given adequately only by someone with experience and first-hand knowledge.

The boards could insure the inclusion of this subject in the medical curriculum by adopting the policy that all applicants for examination or endorsement be required to show a basic knowledge of medical ethics and the medical practice act of the state.

Discipline in Organized Medicine

It soon became evident that, in the matter of medical discipline, the principle of states' rights is of paramount importance. Each state licensure board and each medical society was convinced of the fact, a conviction which is shared by the committee.

Acknowledging this fact, what then are the deficiencies which exist within organized medicine, medical societies and specialty groups? First and foremost, the committee found apathy, substantial ignorance, and a lack of a sense of individual responsibility by physicians as a whole. The latter is demonstrated by the "hear no evil, see no evil" attitude of many doctors and through the complaints which are received concerning physicians when the complaining physician later refuses to testify or give a deposition. Without such cooperation the boards and societies are powerless to act.

Organized medicine has the personnel, funds, and channels of communication to alert, inform, and stress the course of action necessary. The medical press contains too few articles in this field. There is too little factual material being promulgated to the profession and the public.

Due to this lack of forceful leadership, the average physician and constituent and component medical society, or specialty group, have only enough courage and sense of responsibility to discipline the worst and most consistent offenders.

Reports of Disciplinary Action

Another significant finding by the committee is that there is little being done either by medical societies or boards of medical examiners to report their activities in the field of medical discipline. Too frequently the committee received letters stating, "Most disciplinary problems are handled and closed at local level. . . No report is made to the state association."

State boards do not, as a rule, make formal reports to the agency of government which appointed them.

Each state medical association should know of every disciplinary action taken by a component medical society within the state. Without such close liaison the effectiveness of any worthwhile disciplinary program is either completely lost or badly attenuated. The state association in turn should report its disciplinary actions to the national federation office and to the AMA. Such a procedure would supply invaluable information which could serve many purposes.

These reports should routinely be filed and available for use by legitimate authorities in and out of the state. Too often the feeling exists that once the offender has left the immediate vicinity the group's responsibility to and for him is terminated. All derogatory as well as favorable information should be available to all medical societies, specialty groups, and boards of medical examiners. As the situation exists today, liaison and lines of orderly communication between the component groups are virtually non-existent.

Some states were found to be skilled and experienced in handling disciplinary problems. These are usually the states with large population concentrations and with adequate budgets. The states having smaller population, less experience, and a budget inadequate to retain competent administrative, investigative, legal, or research assistance should have available to them the experience of the larger states. The committee has observed the repetition of the same errors simply because the fruits of past experience are buried. The need for greater and freer exchange of information must be given deep and serious consideration.

Boards of Medical Examiners

The boards of medical examiners have a most important role to play in maintaining discipline. This can be recognized from the fact that there are over 250,000 physicians in the United States, and only about 180,000 belong to the American Medical Association. Only the boards have any degree of control over non-members. Secondly, the boards have what organized medicine does not possess legal authority and legal status. This permits them to act with the force of law and without the same fear of lawsuits. Such effective discipline as is maintained in this country today is primarily through the efforts of the medical boards.

In general, the boards have members of high caliber. However, the medical profession should recognize that traits other than just being a respectable practitioner and a good fellow are required. Board work requires a flair for the judicial, for forceful, fairminded and courageous individuals. Too often selections are made on the basis of teaching or scientific accomplishments or as an honor to a respected practitioner. Unless an individual is interested in this field, is willing to work at mastering its complexities, and has the intestinal fortitude to withstand the many complaints and criticisms to which he will be subjected, his ability to serve is limited. In most states the recommendation to serve on the board is made by the state medical society to the governor for appointment. It is, therefore, organized medicine's responsibility to see that proper appointments are made.

Adequate funds are necessary, too, for investigation and enforcement of the laws. The range of funds now available for these purposes varies in the fifty states from five or ten thousand dollars to four hundred thousand dollars, plus. Obviously, those at the lower end have insufficient funds to do more than provide secretarial help, and not much of that. It is impossible for them to operate efficiently and effectively. It is not the boards' responsibility alone to request and urge the appropriation of such funds; it is also the responsibility of individual physicians and of organized medicine. Annual or biennial registration with the payment of a fee is one means to accomplish this. (Re-registration also aids in maintaining adequate control in the field of discipline. Only six states at the present time do not have this as a requirement.)

Medicine, for the most part, has been permitted to maintain itself according to its ideals and traditions. Doctors examine and license doctors. Wisely the state has delegated to the profession initial control over those

who are to practice. Medicine has done this job well. There are relatively few complaints against the boards for their actions in accepting or rejecting candidates for license.

Unfortunately, however, medicine's efforts have largely ceased with the discharge of the licensing function. All too seldom are licensed physicians called to task by boards, societies, or colleagues.

The committee would suggest that greater emphasis be given to ensuring competence and observance of law and ethics *after* licensure. Agencies already exist which can prepare and correct written examinations to be given applicants for medical licensure. Additionally, much more reliance can be placed on our medical schools of today. They are not to be compared with schools as they were operated fifty years ago. Today graduation from a medical school is substantial evidence of good character and a solid background in the science of medicine. Thus it may be an appropriate time to reappraise the primary function of state medical boards.

Borderline Cases

Illegal or clearly unethical acts appear to be far less a problem than borderline cases. Time and time again the committee heard of these gray areas where an act committed was contrary to medicine's high ideals although it did not *technically* violate the law or ethical principles.

These borderline cases represent the most perplexing and disturbing problem of medical discipline. When should a medical society step in? Who should act and how?

What of the doctor who prescribes sedatives or stimulants promiscuously to all who wish to purchase them but disguises his records so that it appears that a bona fide physician-patient relationship existed between him and his "customers"? What about personal matters which do not *per se* affect the doctor's competence? Here is found the ladies' man or the heavy social drinker; the doctor whose professional and social behavior do not quite measure up. He is not a credit to the profession, although he seems to be professionally competent.

Part of the gray area relates to physician-patient relations. The most frequent complaint reportedly made against doctors concerns high fees. Society after society has emphasized that misunderstandings about fees far outnumber all other complaints. To solve this problem, medical society grievance committees have been formed and, based on reports received, they are doing a commendable job. Despite this good organizational work, however, it is clear that doctors as individuals must do more to prevent misunderstandings about fees.

It has been observed that many physicians charge patients according to their ability to pay. Doctors reportedly have increased their fees because they were told or knew that insurance would quite likely pay the bill. This is strange reasoning when it is realized that the physician raises his fee for services to a man who has been so concerned about paying his doctor when necessary that he has been saving his money for that purpose. It isn't just a case of considering the ability of the patient to pay. Rather, consideration should be given to the fact that the individual has actually saved his money for this purpose. For this reason he should be favored rather than penalized because the doctor to some extent has his financial problem lessened.

The American Medical Association's Law Department is conducting an interview survey among insurance carriers and attorneys who represent medical liability defendants for the purpose of highlighting current trends in the medical liability situation. In the course of this survey, which is now nearing completion, several of the leading attorneys and claims executives expressed opinions bearing upon the problems of medical discipline. A top insurance executive made this statement:

Most of the big claims originate out of medical services rendered by physicians in hospitals. Unfortunately, too many hospital medical staffs are loath to cancel or limit the hospital privileges of an established fellow practitioner until his activities become unconscionable. By this time a great deal of damage has already been done. A significant number of malpractice cases never would have occurred if diligence had been exercised in limiting the privileges of physicians who had demonstrated carelessness or incompetence when their inferior work first became evident.

The substance of this statement was expressed independently by other claims men and attorneys. Another insurance executive stated:

Medical societies think that their job is done when a totally incompetent physician is allowed to resign from their society or moves to another community. Similarly, a man thrown out of one hospital too often goes to another hospital where he continues the same type of incompetent work. State licensure boards are not equipped to deal with the problems of discipline unless they receive active cooperation from medical societies with respect to all physicians, whether or not they are members.